		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040360

Facility Name: Park Place

Address: 205 Park Avenue (Number) Pana (City) 62577 (Zip Code)

County: Christian

Telephone Number: (217) 562-7023 **Fax #** (217) 562-5516

IDPA ID Number: 371238076004

Date of Initial License for Current Owners: 05/01/93

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Micheal G. Kaplan **Telephone Number:** (312) 207-2264
Altschuler, Melvoin & Glasser LLP
30 South Wacker Drive
Chicago, IL 60606-7494
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, 30 South Wacker Drive, Chicago, Il 60606-7494
(Telephone) (312) 207-2264 Fax # (312) 207-2958

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,205			5,205	13
14	TOTALS	5,205			5,205	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.88%

D. How many bed-hold days during this year were paid by Public Aid? 62 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 05/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/30/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified N/A and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	A. General Services											
1	Dietary	17,500	2,121	3,126	22,747		22,747		22,747			1
2	Food Purchase		19,080		19,080		19,080	(2,196)	16,884			2
3	Housekeeping		2,577		2,577		2,577		2,577			3
4	Laundry		1,466		1,466		1,466		1,466			4
5	Heat and Other Utilities			8,234	8,234		8,234	43	8,277			5
6	Maintenance	2,997		12,794	15,791		15,791	798	16,589			6
7	Other (specify):*											7
8	**TOTAL General Services**	20,497	25,244	24,154	69,895		69,895	(1,355)	68,540			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	112,479	3,236	2,877	118,592		118,592	289	118,881			10
10a	Therapy			2,208	2,208		2,208		2,208			10a
11	Activities		3,054	110	3,164		3,164	1,181	4,345			11
12	Social Services			1,622	1,622		1,622		1,622			12
13	Nurse Aide Training											13
14	Program Transportation			2,233	2,233		2,233		2,233			14
15	Other (specify):* Routine Dental			422	422		422		422			15
16	**TOTAL Health Care and Programs**	112,479	6,290	13,072	131,841		131,841	1,470	133,311			16
	C. General Administration											
17	Administrative	32,864		18,885	51,749		51,749	(18,885)	32,864			17
18	Directors Fees							4,119	4,119			18
19	Professional Services			7,645	7,645		7,645	11,630	19,275			19
20	Dues, Fees, Subscriptions & Promotions			1,746	1,746		1,746	277	2,023			20
21	Clerical & General Office Expenses	19,524	3,240	7,392	30,156		30,156	9,766	39,922			21
22	Employee Benefits & Payroll Taxes			12,718	12,718		12,718	21,677	34,395			22
23	Inservice Training & Education			250	250		250	799	1,049			23
24	Travel and Seminar			1,458	1,458		1,458	1,987	3,445			24
25	Other Admin. Staff Transportation			1,245	1,245		1,245	114	1,359			25
26	Insurance-Prop.Liab.Malpractice							4,355	4,355			26
27	Other (specify):*											27
28	**TOTAL General Administration**	52,388	3,240	51,339	106,967		106,967	35,839	142,806			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	185,364	34,774	88,565	308,703		308,703	35,954	344,657			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Park Place #0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			15,103	15,103		15,103	741	15,844			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,139	48,139		48,139	5,316	53,455			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							1,386	1,386			34
35	Rent-Equipment & Vehicles			7,459	7,459		7,459	1,506	8,965			35
36	Other (specify):*											36
37	**TOTAL Ownership**			70,701	70,701		70,701	8,949	79,650			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			87	87		87		87			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			15,324	15,324		15,324	15,326	30,650			42
43	Other (specify):* **Nonallowable costs**			114,332	114,332		114,332	(114,332)				43
44	**TOTAL Special Cost Centers**			129,743	129,743		129,743	(99,006)	30,737			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	185,364	34,774	289,009	509,147		509,147	(54,103)	455,044			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(113,088)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,054)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(118)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(660)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	534			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,386)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	60,283		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 60,283		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (54,103)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park Place
Provider # 0040360
June 30, 2000

Schedule 5A

VI. Adjustment Detail
Line 29-Other (Specify)

	Amount	Sch V Reference
Offset Miscellaneous Income	724	21
Out of State Travel & Seminar	(190)	43
	534	

See Accountants' Compilation Report

STATE OF ILLINOIS

Park Place

ID# 0040360

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc. - See attached Schedule 7A	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 255	$ 255	1
2	V	10	Medical supplies		Center for Residential Management, Inc.	**	289	289	2
3	V	11	Activity programming		Center for Residential Management, Inc.	**	1,110	1,110	3
4	V	17	Management fees	7,906	Center for Residential Management, Inc.	**	7,919	13	4
5	V	18	Board fees		Center for Residential Management, Inc.	**	755	755	5
6	V	19	Professional fees		Center for Residential Management, Inc.	**	1,344	1,344	6
7	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	117	117	7
8	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	3,890	3,890	8
9	V	22	Employee benefits & payroll taxes		Center for Residential Management, Inc.	**	10,653	10,653	9
10	V	23	Inservice travel & education		Center for Residential Management, Inc.	**			10
11	V	24	Travel & seminar		Center for Residential Management, Inc.	**	788	788	11
12	V	25	Vehicle expense		Center for Residential Management, Inc.	**	90	90	12
13	V	26	Vehicle, fire & liability insurance		Center for Residential Management, Inc.	**	57	57	13
14	Total			$ 7,906			$ 27,267	$ * 19,361	14

** Center for Residential Management, Inc. is Progressive Housing, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Center for Residential Management, Inc.	**	$ 315	$ 315	15
16	V	32	Interest expense		Center for Residential Management, Inc.	**	205	205	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 520	$ * 520	39

** Center for Residential Management, Inc. is SEE ACCOUNTANTS' COMPILATION REPORT Progressive Housing, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Progressive Housing, Inc.	100.00%	$ 33,820	$ 33,820	15
16	V	18	Board fees		Progressive Housing, Inc.	100.00%	3,364	3,364	16
17	V	19	Professional fees		Progressive Housing, Inc.	100.00%	5,058	5,058	17
18	V	20	Licenses, dues & subscriptions		Progressive Housing, Inc.	100.00%	3	3	18
19	V	21	Office supplies & telephone		Progressive Housing, Inc.	100.00%	552	552	19
20	V	22	Employee benefits & payroll taxes		Progressive Housing, Inc.	100.00%	6,482	6,482	20
21	V	24	Travel & seminar		Progressive Housing, Inc.	100.00%	112	112	21
22	V	26	Vehicle, fire & liability insurance		Progressive Housing, Inc.	100.00%	3,929	3,929	22
23	V	32	Interest expense		Progressive Housing, Inc.	100.00%	3,378	3,378	23
24	V	42	Provider participation fees		Progressive Housing, Inc.	100.00%	15,326	15,326	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 72,024	$ * 72,024	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 43	$ 43	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	543	543	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	71	71	17
18	V	17	Management fees	52,718	Developmental Services of Illinois, Inc.	**		(52,718)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	5,228	5,228	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	157	157	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	4,600	4,600	21
22	V	22	Employee benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,346	2,346	22
23	V	23	Inservice travel & education		Developmental Services of Illinois, Inc.	**	799	799	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	1,087	1,087	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	24	24	25
26	V	26	Vehicle, fire & liability insurance		Developmental Services of Illinois, Inc.	**	369	369	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	426	426	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	2,511	2,511	28
29	V	34	Rent		Developmental Services of Illinois, Inc.	**	1,386	1,386	29
30	V	35	Vehicle lease & equipment rental		Developmental Services of Illinois, Inc.	**	1,506	1,506	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,718			$ 21,096	$ * (31,622)	39

** Developmental Services of Illinois, Inc. is Progressive Housing, Inc.'s management company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Ron Schroeder	Secretary	Board Member	None	13,412	2 hrs/mtg.		Director	$ 388	L18,C8	1
2	Darrell Boehne	President	Board Member	None	12,657	2 hrs/mtg.		Director	343	L18,C8	2
3	Edward Childers	Vice President	Board Member	None	13,675	2 hrs/mtg.		Director	325	L18,C8	3
4	Cora Flota	Director	Board Member	None	4,195	2 hrs/mtg.		Director	605	L18,C8	4
5	Orland Bauer	Director	Board Member	None	7,696	2 hrs/mtg.		Director	1,104	L18,C8	5
6	Kay Schuman Johnson	Treasurer	Board Member	None	2,920	2 hrs/mtg.		Director	1,080	L18,C8	6
7	Bob Bauer	Director	Board Member	None	11,887	2 hrs/mtg.		Director	113	L18,C8	7
8	Eugene Humphrey	Director	Board Member	None	7,887	2 hrs/mtg.		Director	113	L18,C8	8
9	Shawn Jeffers	Director	Board Member	None	3,152	2 hrs/mtg.		Director	48	L18,C8	9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	$ 4,119		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	206,424	20	$ 6,488	$	5,856	$ 184	1
2	10	Medical supplies	Bed days available	206,424	20	10,160		5,856	288	2
3	17	Management fees	Bed days available	206,424	20	279,150		5,856	7,919	3
4	18	Board fees	Bed days available	206,424	20	26,600		5,856	755	4
5	19	Professional fees	Bed days available	206,424	20	47,365		5,856	1,344	5
6	20	Licenses, dues & subscriptions	Bed days available	206,424	20	401		5,856	11	6
7	21	Office supplies & telephone	Bed days available	206,424	20	14,574		5,856	413	7
8	22	Employee benefits & payroll taxes	Bed days available	206,424	20	27,615		5,856	783	8
9	24	Travel & seminar	Bed days available	206,424	20	7,941		5,856	225	9
10	25	Vehicle expense	Bed days available	206,424	20	3,189		5,856	90	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	2,009		5,856	57	11
12	30	Depreciation	Bed days available	206,424	20	11,103		5,856	315	12
13	32	Interest expense	Bed days available	206,424	20	7,240		5,856	205	13
14										14
15										15
16	6	Repairs & maintenance	Direct method						71	16
17	11	Activity programming	Direct method						1,110	17
18	20	Licenses, dues & subscriptions	Direct method						105	18
19	21	Office supplies & telephone	Direct method						3,479	19
20	22	Employee benefits & payroll taxes	Direct method						9,870	20
21	24	Travel & seminar	Direct method						563	21
22										22
23										23
24										24
25	TOTALS					$ 443,835	$		$ 27,787	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Progressive Housing, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Direct method			$	$		$ 33,820	1
2	18	Board fees	Direct method						3,364	2
3	19	Professional fees	Direct method						5,058	3
4	20	Licenses, dues & subscriptions	Direct method						3	4
5	21	Office supplies & telephone	Direct method						552	5
6	22	Employee benefits & payroll taxes	Direct method						6,482	6
7	24	Travel & seminar	Direct method						112	7
8	26	Vehicle, fire & liability insurance	Direct method						3,929	8
9	32	Interest expense	Direct method						3,378	9
10	42	Provider participation fees	Direct method						15,326	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 72,024	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	206,424	20	$ 1,518	$	5,856	$ 43	1
2	6	Repairs & maintenance	Bed days available	206,424	20	19,133		5,856	543	2
3	11	Activity programming	Bed days available	206,424	20	2,500		5,856	71	3
4	19	Professional fees	Bed days available	206,424	20	184,323		5,856	5,228	4
5	20	Licenses, dues & subscriptions	Bed days available	206,424	20	5,518		5,856	157	5
6	21	Office supplies & telephone	Bed days available	206,424	20	162,176		5,856	4,600	6
7	22	Employee benefits & payroll taxes	Bed days available	206,424	20	82,697		5,856	2,346	7
8	23	Inservice travel & education	Bed days available	206,424	20	28,154		5,856	799	8
9	24	Travel & seminar	Bed days available	206,424	20	38,328		5,856	1,087	9
10	25	Vehicle expense	Bed days available	206,424	20	846		5,856	24	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	13,012		5,856	369	11
12	30	Depreciation	Bed days available	206,424	20	15,000		5,856	426	12
13	32	Interest expense	Bed days available	206,424	20	88,507		5,856	2,511	13
14	34	Rent	Bed days available	206,424	20	48,842		5,856	1,386	14
15	35	Vehicle lease & equipment rental	Bed days available	206,424	20	53,081		5,856	1,506	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 743,635	$		$ 21,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Drive-Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IL Health Fac. Auth. - Bond		x	Acquisition of facility	Various	03/01/93	$ 4,527,000	$ 534,820	08/15/16	Varies	$ 44,877	1
2	Lease Obligation - NCS		x	Hardware/Software	$94.00	10/31/98	3,756	2,364	09/30/03	0.1429	247	2
3												3
4												4
5								Amortization of bond costs			2,487	5
	Working Capital											
6	Community Bank of Galesburg		x	Working Capital	None	06/07/00	286,000	27,765	09/07/00	0.1000	3,246	6
7												7
8												8
9	TOTAL Facility Related				$94.00		$ 4,816,756	$ 564,949			$ 50,857	9
	B. Non-Facility Related*											
10							Miscellaneous interest				660	10
11							Offset interest income				(118)	11
12							Non-allowable finance charges				(660)	12
13							Allocation from parent & management company				2,716	13
14	TOTAL Non-Facility Related						$	$			$ 2,598	14
15	TOTALS (line 9+line14)						$ 4,816,756	$ 564,949			$ 53,455	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,625 B. General Construction Type: Exterior Siding Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	13,916	1993	$ 20,000	1
2					2
3	TOTALS	13,916		$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1992	$ 406,000	$ 10,150	40	$ 10,150	$	$ 72,741	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	6,700	447	15	447		2,455	9
10	Heating piping			1997	650	43	15	43		108	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 413,350	$ 10,640		$ 10,640	$	$ 75,304	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 45,144	$ 4,463	$ 4,463	$	5-10 years	$ 30,155	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40	Allocation from parent & management company			741	741			40
41	TOTALS	$ 45,144	$ 4,463	$ 5,204	$ 741		$ 30,155	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 478,494	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 15,103	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 15,844	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 741	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 105,459	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocation from parent and management company				1,386			6
7	TOTAL				$ 1,386 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 1,762 Description: Postage meter - $259; allocation from management company-$1,503
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1995 Ford van	$ 600.00	$ 7,200	17
18					18
19	Allocation from management company			3	19
20					20
21	TOTAL		$ 600.00	$ 7,203	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   ☐ YES
   ☒ NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Eye care	L39,C3			1	87		1	87	13
14	TOTAL			$	1	$ 87	$	1	$ 87	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	92,694	92,694	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,232	2,232	6
7	Other Prepaid Expenses	12,939	12,939	7
8	Accounts Receivable (owners or related parties)	409,686	409,686	8
9	Other(specify): Prepaid Deposit	600	600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 518,151	$ 518,151	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	413,350	413,350	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	45,144	45,144	16
17	Accumulated Depreciation (book methods)	(105,459)	(105,459)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs	39,373	39,373	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 412,408	$ 412,408	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 930,559	$ 930,559	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,165	$ 61,165	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	27,765	27,765	29
30	Accrued Salaries Payable	9,865	9,865	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	20,690	20,690	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	60,978	60,978	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 180,463	$ 180,463	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,364	2,364	39
40	Mortgage Payable			40
41	Bonds Payable	534,820	534,820	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 537,184	$ 537,184	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 717,647	$ 717,647	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 212,912	$ 212,912	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 930,559	$ 930,559	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Park Place
Provider # 0040360
June 30, 2000

Schedule 17A

XV. Balance Sheet

Line 36 - Other	Operating	After Consolidation
Accrued Expense	30,418	30,418
Accrued Legal & Accounting	5,161	5,161
Accrued Participation	7,661	7,661
Accrued Bond Payments	17,738	17,738
	60,978	60,978

See Accountants' Compilation Report

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 195,439	1
2	Restatements (describe):		2
3	**Prior Period Audit Adjustment**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 195,442	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	104,689	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent & management company allocation**		15
16	Other (describe) **added back in column 7**	(87,219)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 17,470	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 212,912	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 500,630	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 500,630	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	113,088	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 113,088	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	118	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 118	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 613,836	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	69,895	31
32	Health Care	131,841	32
33	General Administration	106,967	33
	B. Capital Expense		
34	Ownership	70,701	34
	C. Ancillary Expense		
35	Special Cost Centers	114,419	35
36	Provider Participation Fee	15,324	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 509,147	40
41	**Income before Income Taxes (line 30 minus line 40)****	104,689	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 104,689	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A federal tax return is filed for the combined divisions of Progressive Housing, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	67	67	1,350	20.15	3
4	Licensed Practical Nurses	503	507	5,607	11.06	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,328	2,474	17,500	7.07	15
16	Dishwashers					16
17	Maintenance Workers	208	210	2,997	14.27	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,557	1,593	26,635	16.72	20
21	Assistant Administrator					21
22	Other Administrative	260	269	6,229	23.16	22
23	Office Manager					23
24	Clerical	721	740	19,524	26.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	13,645	14,556	105,522	7.25	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,289	20,416	$ 185,364 *	$ 9.08	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	45	$ 3,081	L1,C3	35
36	Medical Director	Monthly	3,600	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	414	L10,C3	38
39	Pharmacist Consultant	Monthly	164	L10,C3	39
40	Physical Therapy Consultant	3	138	L10A, C3	40
41	Occupational Therapy Consultant	16	942	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	21	1,128	L10A, C3	43
44	Activity Consultant	9	1,110	L11,C8	44
45	Social Service Consultant	20	1,622	L12,C3	45
46	Other(specify) Psychological	Monthly	2,299	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	114	$ 14,498		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Serrano	Administrator	0.00%	$ 13,120
Karen DeMoulin	Administrator	0.00%	3,167
Christine Hamilton	Administrator	0.00%	6,576
Beth Shaks	Administrator	0.00%	3,772
Parent Company Allocation	See Schedule 21A		6,229
TOTAL (agree to Schedule V, line 17, col. 1)			$ 32,864
(List each licensed administrator separately.)			

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. - Management fees	$ 10,979
Center for Residential Management, Inc. - Management fees	7,906
(Management fees eliminated in Schedule V, col. 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 18,885
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consultation	$ 167
Altschuler, Melvoin & Glasser LLP	Accounting	7,082
American Express Tax &	Accounting	246
Business Services		
Mangum, Smietanka & Johnson	Legal	150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,645

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,758
Unemployment Compensation Insurance	1,889
FICA Taxes	14,098
Employee Health Insurance	8,837
Employee Meals	2,196
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	61
Other Employee Benefits	556
TOTAL (agree to Schedule V, line 22, col.8)	$ 34,395

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	430
Health Care Worker Background Check	
(Indicate # of checks performed 13)	92
Illinois Health Care Association	826
Miscellaneous dues & subscriptions	350
Miscellaneous license & fees	180
Allocation from management company	145
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,023

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,611
Seminar Expense	522
Allocated from parent company	225
Allocated from management company	1,087
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,445

* Attach copy of IMRF notifications

**See instructions.

Park Place
Provider # 0040360
June 30, 2000

Schedule 21C

XIX. Support Schedules
C. Professional Services

	Type	Amount
Total agreeing to Schedule V, line 19,column 3		**7,645**
Allocation from parent company		
Altschuler, Melvoin & Glasser LLP	Accounting	466
American Express Tax & Business Services	Accounting	77
Mangum, Smietanka & Johnson	Legal	801
Allocation from management company		
American Express Tax & Business Services	Accounting	797
Altschuler, Melvoin & Glasser LLP	Accounting	1,512
ADP	Payroll Processing	2,589
Health Outcomes	Consulting	330
Allocation from PHI Corporation		
Altschuler, Melvoin & Glasser LLP	Accounting	3,756
American Express Tax & Business Services	Accounting	100
Mangum, Smietanka & Johnson	Legal	1,202
Total adjustments & allocations		11,630
Total agreeing to Schedule V, line 19, column 8		**19,275**

See Accountants' Compilation Report

Park Place
PROVIDER #0040360
6/30/2000

LINE 24 DETAIL:

EDUCATION/SEMINARS	522
ADMIN TRAVEL	925
ADMIN MEALS	33
ADMIN LODGING	308
SEMINAR TRAVEL	183
SEMINAR LODGING	162
	2,133
PARENT COMPANY ALLOCATION	225
MANAGEMENT COMPANY ALLOCATION	1,087
	$ 3,445

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8						N/A							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-$826**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **n/a**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **205** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **30,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **2,196** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **62%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.